MONTANA
Department of Public Health & Human Services

Your New Handbook

What you need to know

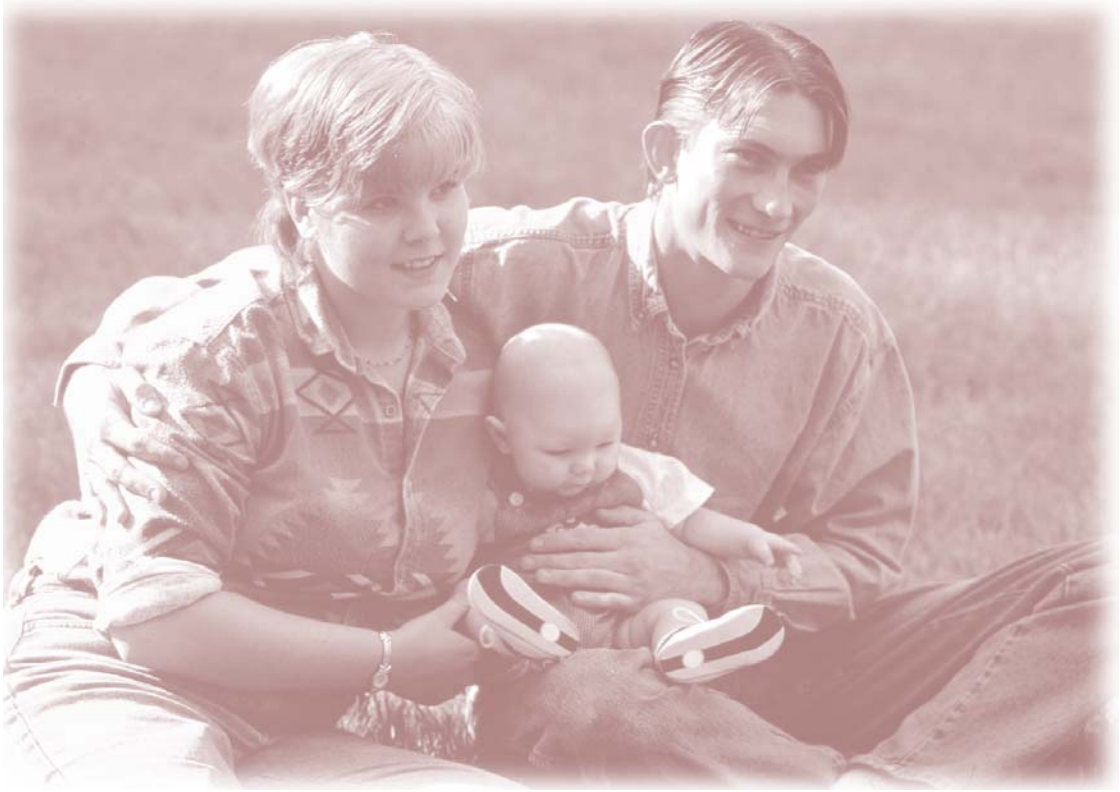

Photo: John Reddy

HPS-165 (Rev 7/2004)

July 2004

Dear Medicaid Client:

This handbook contains the most current information about your ***Medicaid Health Insurance Services*** as of July 2004.

The information in this handbook is subject to change due to budget cuts or other requirements. We will do our best to keep you informed of these changes in Medicaid coverage. *It is important* for you to watch your mail for Medicaid notices and updates.

If you have questions about Medicaid, contact the Montana Medicaid Help Line at 1-800-362-8312.

Also, keep in contact with your County Office of Public Assistance. Addresses and phone numbers can be found on pages 68 and 69 of this handbook.

Gail Gray

Gail Gray, Ed. D.
Director
Montana Department of Public Health and Human Services

Where do I call with questions?

Eligibility	Call your local County Office of Public Assistance (see pages 68 and 69 of this book for address and phone number)
General Medicaid	1-800-362-8312
Health Insurance Premium Payment Program	1-800-694-3084
Medicaid Fraud	1-800-376-1115
Montana Relay Services	Voice: 1-800-253-4093 TDD: 1-800-253-4091
Nurse First	Call your local Office of Public Assistance or the Medicaid Help Line
Telecommunication Device for the Deaf & Hard of Hearing	1-800-833-8503
Transportation Center (approval *before* travel)	1-800-292-7114

~ Please see page 68 for more telephone numbers ~

Those with disabilities who need an alternative accessible format of this information, or who require other reasonable accommodation in order to participate in Medicaid, should contact the Montana Department of Public Health and Human Services:

Montana Medicaid Help Line
PO Box 254
Helena, MT 59624-0254

Phone: 1-800-362-8312
Fax: 1-406-442-2328

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Medicaid covered services (continued)

SECTION 1
Medicaid

Photo: John Reddy

What is Medicaid?

Medicaid is a program to help low income Montanans pay for medical bills. Medicaid only pays for some services. When you are eligible for Medicaid you will either have *full* or *basic* coverage. See page 24, "Medicaid Coverage – Full Benefits and Basic Benefits" for an explanation.

Your local Office of Public Assistance (OPA) eligibility case manager will tell you which coverage you have – in person if you have an interview, and in your approval notice. Be sure to read your notices carefully or ask your eligibility case manager again if you are not sure which coverage you have. *It is your responsibility to know* if you have full or basic benefits, and to understand which Medicaid services are covered – see the "Medicaid Services Chart" starting on page 34, and the "Detailed List of Some Medicaid Covered Services" starting on page 42.

How do I get Medicaid?

Go to your local County Office of Public Assistance to apply for Medicaid. A list of local County Offices of Public Assistance is on pages 68 and 69 of this book.

When will I get my Medicaid card?

Everyone on Medicaid will get a plastic Medicaid card in the mail after being approved for Medicaid. Each person on Medicaid will get their own card.

Don't throw your card away, even if your Medicaid ends. Keep the card! You will use the same plastic card if you become eligible in the future. Keep it in a safe place, like a purse or a wallet. You will need it to get Medicaid services. *If the information on the card is not right,* tell your Eligibility Case Manager at your local County Office of Public Assistance as soon as possible. To find the phone number of your local Office, call the Medicaid Help Line at 1-800-362-8312.

Always take your Medicaid card with you when you go for medical care and show it to the person at the front desk.

If you don't take your card and you can't prove you have Medicaid, you may have to pay the bill yourself. If you have not received your card and you need medical care, contact your eligibility case manager at your local County Office of Public Assistance.

What is on the Medicaid card?

Your Medicaid card will have your name, your Medicaid number (called your member number) and your birth date. On page 10, there is an example of a card and explanations of what the different items on the card mean. If you find a mistake on your card, call your Eligibility Case Manager.

How long do I get Medicaid?

Your local County Office of Public Assistance will send you a letter telling you when your Medicaid begins and another letter telling you when your Medicaid will end.

What if I move? Get married? Have a baby?

You must tell your Eligibility Case Manager if you have **any** changes in your household. Some examples are changes in living arrangements, getting married, separated, divorced, pregnant, having a baby, changing jobs, receiving other income, or any other changes to your household. You must tell your Eligibility Case Manager *within ten days of knowing of the change.* Your Eligibility Case Manager will let you know what you need to do to see if you are still eligible for Medicaid.

Whether you're moving next door or across the country, you must report your move to your current Eligibility Case Manager.

Cost sharing — What do I have to pay?

You must pay a small amount – a 'cost share' – for many services if you are:

- age 21 or over,
- **not** pregnant*, or
- living outside a nursing home.

Providers are allowed to charge interest on unpaid cost sharing balances.

Clients age 20 and under *do not* pay cost sharing for Early and Periodic Screening, Diagnostic and Treatment (EPSDT – see page 32). See page 25 for examples of services exempt from cost sharing and for more information.

* Under Medicaid definitions, pregnancy lasts 60 days past the last day of pregnancy (delivery) and through the end of that month. If you are pregnant, it's your responsibility to tell your provider each time you receive services.

PASSPORT to Health

Most Medicaid clients are on the PASSPORT to Health Managed Care program. If you're on PASSPORT, you are required to choose a *primary care provider* – your PASSPORT provider. Once you choose, you will get a letter in the mail with the name of your PASSPORT provider and their after-hours phone number.

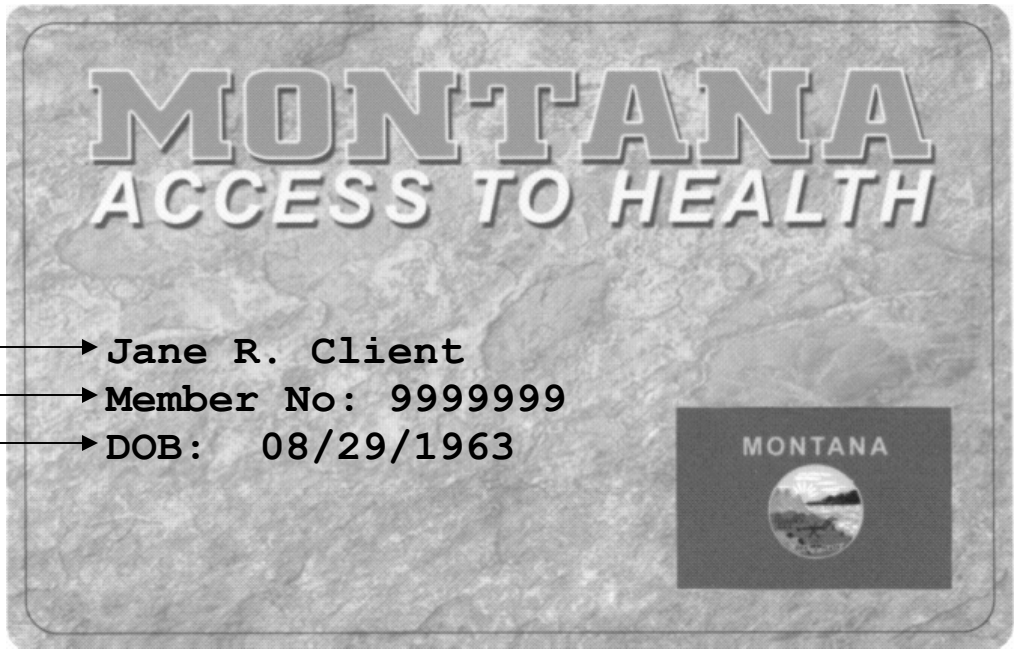
For most services, you must see your PASSPORT provider or get their authorization before going to another provider or to the hospital for a non-emergency. If you don't get your PASSPORT provider's okay or authorization, Medicaid may not pay and you may have to pay the bill.

Nurse First – Advice Line and Disease Management services

It can be very helpful to *call Nurse First* before going to your health care provider or the emergency room – the Nurse First advice line provides health care services when you are sick, hurt, or have health care questions. Registered nurses ask about your symptoms, and can provide friendly, professional advice.

Nurse First Disease Management helps clients with asthma, diabetes, heart failure, chronic pain, and cancer learn more about their disease, and help them feel better. These services are preformed by specially-trained, registered nurses either by telephone or in person. See page 61 for information.

Sample Medicaid 'Hard Card'



What each part of the Medicaid Card means:

1. Client name – the name of the person eligible for services.
2. Member number. This number is only an identification number for the person listed on the Hard Card. It is not your social security number.
3. Short for Date Of Birth – your birthday.

Doing your part – your responsibilities

Your health care

You and your health care provider are a team. Your job is to help your health care provider give you the best health care. Here is what you can do:

- **Treat your doctor and other health care providers with respect, just as you would like to be treated.**
- **Call Nurse First – *first*.**
  Call the Nurse First advice line before you visit your health care provider or the emergency room to insure you get the care you need at the right place. This can save time, money, and grief due to prolonged waiting periods in a doctor's office or waiting room. This also helps friends, neighbors and fellow Montanans, as it helps make the best use of the health care system.
- **Don't use an ambulance or the emergency room if it is not an emergency.**
  If you go to the emergency room for routine care, Medicaid won't pay the bill. An emergency room visit costs at least $150 – a visit to your provider costs *much* less.
  - An *emergency* means the symptoms seem so severe that a prudent layperson (a person with average knowledge of health and medicine) would expect there might be danger to the health of the individual unless the symptoms were treated immediately.
  - Emergency ambulance services are covered for emergency ground or air transports. Call 911 or your local emergency number for services. If it is not en emergency Medicaid will not pay.
  - On weekends and evenings, you may call your provider or the Nurse First for advice on illnesses that are not serious.
- **Call ahead for an appointment.**
  Most doctors and other providers don't have time to see drop-in patients. Ask if the provider accepts Medicaid. Ask if Medicaid covers what you need. Get your PASSPORT provider's approval, if you are on PASSPORT. (See page 58, "PASSPORT To Health managed care program")
- **Keep your appointments and be on time.**
  Call ahead of time if you are going to be late or can't keep your appointment. A missed appointment is costly to your provider. Many have policies that they will not see you again if you have missed an appointment. Letting your provider know you can't keep the appointment may make it available for another patient.

Doing your part (continued)

- **Medical records.**
  Help your health care provider get your previous records or fill out new ones.
- **Keep your health care provider informed.**
- Tell your health care provider about any signs of trouble, pain, allergies, or changes you've noticed, and unusual health needs as well.
- **Ask questions.**
  It may help to write a list of questions before you go to your appointment. Ask about risks, choices, and costs before getting treatment or prescriptions.
- **Always have your prescriptions filled at the same pharmacy.**
  The pharmacy will be able to tell you if a drug combination will have problems or side effects. The pharmacist can also answer questions you have about your prescriptions.
- **Get complete directions about all medications, treatments, or tests**.
  Write them down, or ask your provider to write them down.
- **Take time to decide about having a treatment or procedure before it happens.**
  Think about your choices before deciding on a treatment or procedure. Discuss your options with your health care provider. For some procedures, your provider will need Medicaid approval before services are provided.
- **Don't sign anything you don't understand.**
  Ask questions until you do understand. Think about what will happen if you don't have a procedure done.
- **Pay your cost shares.**
  See Section 2 starting on page 25 for details.
- **Pay your health care provider any money you receive from your insurance company or other payers for medical services.**
- **Use Medicaid wisely.**
  Use Medicaid only when you are sick or for regular checkups to help prevent sickness. If you misuse Medicaid services, you could lose your freedom to choose your own health care provider and pharmacy.

Your rights under Medicaid

You have the right to:

- Expect the same quality of medical care available to the general public.
- Be treated politely and with respect by health care providers and their staff.
- Participate in decisions about your health care.
- Understand your medical conditions.
- Discuss the treatment your provider advises *before* it happens.
- Receive information on treatment options.
- Refuse treatment to the extent of the law.
- Discuss possible results with your provider before accepting or refusing treatment.
- Talk to your health care provider and expect that conversations with your provider and your medical records are kept private.
- Use the services of an interpreter if necessary, at no cost to you.
- Make a complaint about Medicaid and receive an answer.
- Know what medical services are covered or paid for by Medicaid.
- Receive information about Medicaid. Ask questions!
- Choose your medical provider. (Unless you are on the Team Care program – see page 58.)

How to file a Medicaid complaint

Denial of Medicaid eligibility

If you've been denied Medicaid, you can contact your County Office of Public Assistance to find out why. They can also tell you how to appeal. The address and phone numbers are at the back of this booklet.

Denial of Medicaid payment

If Medicaid has denied payment for a service, you have the right to appeal that denial within 90 days. Your appeal must be in writing. Contact:

DPHHS Office of Fair Hearings
P.O. Box 202953
Helena, MT 59620-2953

Discrimination

As a recipient of federal financial assistance, the Montana Department of Public Health and Human Services does not exclude, deny benefits to, or otherwise discriminate against anyone on the basis of race, color, national origin, age, sex, handicap, political beliefs, religion, or disability. This includes admission, participation, or receipt of services or benefits of any of its programs, activities or employment, whether carried out by the department, through a contractor or other entity.

To file a complaint, use the form on the next page or contact:

Complaint Coordinator
Phone: (406) 444-3136
TDD Number: 1-800-253-4091

Or, you may wish to file a complaint with the Office of Civil Rights. A grievant alleging discrimination is not obligated to use or exhaust an administrative grievance process in order to exercise their right to file a complaint with the following:

Office for Civil Rights
U.S. Department of Health and Human Services
1961 Stout Street, Room 1426
Denver CO 80294-3528

Phone: (303) 844-2024
TDD Number: (303) 844-3439

Duplicate billing

If you believe a provider is charging both you and Medicaid for the same services, or charging Medicaid for services you did not receive, please call the Montana Citizen's Advocate Office: 1-800-332-2272.

Stop Medicaid abuse!

If you believe someone is abusing Medicaid, using services excessively or inappropriately, please call (406) 444-1518 or write to:

DPHHS / Managed Care Bureau
PO Box 202951
Helena MT 59620

Department of Public Health and Human Services
Client Complaint Resolution Form

Name: _____

Mailing Address: _____

_____

_____

Telephone Number_____ (8:00 a.m. to 5:00 p.m., M-F)

Please explain what you believe to be discriminatory action taken against you and the law or regulation violated. Be specific. Include dates, names, places, actions/events, witnesses (including phone numbers and addresses). Attach additional sheets if necessary.

_____

_____

_____

_____

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_____ [ ] Additional page(s)

Specific corrective action you are seeking: _____

_____

_____

_____

_____ [ ] Additional page(s)

_____ _____
Signature Date

Alternative accessible formats of this document are available on request. For more information, or to submit a complaint, contact: DPHHS Human Resources, Client Complaint Coordinator, P.O. Box 4210, Helena, MT 59604, (406) 444-3136, or Health and Human Services, 1961 Stout Street, Room 1426, Denver CO 80294-3528.

Department of Public Health & Human Services
Americans with Disabilities Act
Complaint Resolution Form

Name: _____

Mailing Address: _____

_____

_____

Telephone Number_____ (8 a.m. to 5 p.m., Monday-Friday)

Please explain what discriminatory action was taken against you. Be specific. Include dates, names, places, actions/events, witnesses, etc. (attach additional sheets if necessary):

_____

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_____ [ ] Additional page(s)

Specific corrective action you are seeking: _____

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_____ [ ] Additional page(s)

_____ _____
Signature Date

Alternative accessible formats of this document are available on request. For further information, or to submit a complaint, contact: DPHHS Human Resources, ADA Coordinator, P.O. Box 4210, Helena, MT 59604, (406) 444-3136.

Getting the most from your health care

Here's how you can help yourself and your family:

Medicaid is paid for with tax dollars. As a partner in your own health care, it is up to you to help keep health care costs low. Here are some things you can do to get the most from Medicaid dollars:

Make healthy lifestyle choices for yourself and your children.

Keep your children healthy!

- **Never smoke while you are pregnant**.
  Smoking could cause serious harm to your baby. It puts kids at risk for Attention Deficit Disorder (ADD), diabetes, Sudden Infant Death Syndrome (SIDS) and low birth weight.
- **Live in a smoke-free place.**
  Children who grow up in homes where people smoke are sick more often than others and can have serious breathing problems. If you smoke, your second-hand smoke can harm your children and may cause bronchitis and asthma.
- **Make sure they get enough rest.**
  Children's muscles, bones, and brains need plenty of rest to grow and work right. Set a regular bed time for your children and stick to it. Children under six usually need regular naps, too.
- **Help them exercise and be active.**
- **Feed them a healthy diet.**
- **Help your children brush and floss every day.**
  See the dentist at least once a year and have fluoride treatments.
- **Make sure your children have Well Child check-ups and have their Immunizations (shots)**.
  Well Child check-ups and shots help protect children from serious diseases such as mumps and measles.
  See "Getting Regular Check Ups for Your Children" on page 32 for more information.

- ***Call Nurse First* before going to the doctor or emergency room.**

Keep Yourself Healthy

- **Stop smoking.**

  Smoking causes many serious illnesses, such as:
  - lung cancer
  - emphysema
  - other breathing problems
  - some forms of heart disease

- **Limit or stop drinking alcohol.**

  Alcohol is linked to major birth defects, serious accidents, and many health problems, including cirrhosis of the liver, swelling of the pancreas, brain and heart damage, and cancer. If you decide to drink, drink moderately. ***Never drink alcohol when you are pregnant.***

- **Exercise regularly and maintain a healthy weight.**

  Try to get at least 30 minutes of moderate activity every day. You don't even have to do the full 30 minutes at one time. Something as simple as three 10-minute brisk walks can help you control your weight. Talk to your medical provider about your ideal weight.

- **Eat a balanced diet with different foods.**

  Choose a variety of grains, fruits, vegetables, and lean meat daily. Choose beverages and other foods that are low in sugar. Choose and prepare foods that are low in salt.

- **Practice safe sex by using protection to avoid unwanted pregnancy and sexually transmitted diseases.**

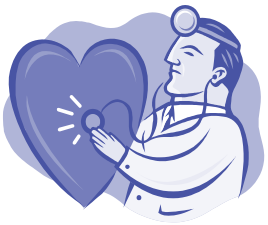
  Careful use of birth control will reduce the risks of unwanted pregnancies. Using condoms will reduce the risk of getting sexually transmitted diseases. Abstain from unprotected sex to avoid unwanted pregnancy and sexually transmitted disease.

- **Select one primary care provider and get regular health check-ups. Having one regular provider:**
  - means all of your medical records are in one place
  - means the provider has your health history
  - gives the provider a chance to learn about you while you are well
  - gives you a chance to know your provider
  - gives you a chance to ask questions
  - means you have a provider to call if you need care after office hours
  - means you have someone to suggest a specialist if you need one.

- **Use health screening benefits.**

  Screening means testing whether you have, or are at risk of getting, a disease. You can use programs such as Baby your Baby, and EPSDT (Early and Periodic Screening, Diagnosis and Treatment) for children and teens age 20 and under, for cholesterol, blood pressure, health risk check, preventative check ups, etc. These services can help identify and reduce risks before they become serious illnesses.

  - Ask your provider about getting a cholesterol and blood pressure test.
  - Ask your provider about when you should get regular check ups.



- **Call 'Nurse First'.**

  Sometimes you may not be sure you need to see a doctor. The Nurse First advice line can help you make the decision. Call any time – day or night. Call about any health care question or concern. Friendly nurses will help you sort things out and get the care you need.

- **Ask for a second opinion.**

  When your health is at stake, it may be wise to get advice from more than one provider. If you see another provider for a second opinion, be sure to take test results and x-rays with you so they won't have to be done over again. Get your PASSPORT provider's referral, if you are on PASSPORT.

- **Ask for generic prescriptions.**

  Generic drugs aren't "brand name," but they still have the same ingredients.
  - Generic drugs are often less costly than brand names.
  - Your cost for generics is less than it would be for brand names.

  Ask your provider or pharmacist if a generic drug would work for you.

- **Check your hospital charges.**

  Keep a record of services while you're in the hospital, then ask to look at your *itemized* bill, and compare charges. Be sure you received everything on the bill!

- **Get a receipt for cost shares that you pay to providers.**

  You may be able to use them if you're a "Medically Needy" client. Talk with your eligibility case manager about this.

SECTION 2
Medicaid Services

Medicaid-covered services

Covered services are services Medicaid will pay for – not all services are covered. Services must be:

- medically necessary
- provided by a health care provider who accepts Medicaid
- on the list of Medicaid-covered services.

If you have a question about Medicaid benefits or covered services, call the Medicaid Help Line at 1-800-362-8312. For a general list of some covered services, see the "Medicaid Services Chart" and "Detailed list of some Medicaid-covered services" starting on page 34.

Medicaid coverage

When you are eligible for Medicaid, you will either have *FULL* or *BASIC* benefits. They are different. *It is your responsibility to know which Medicaid benefits you have* – look at the "Medicaid Services Chart" and "Detailed list of some Medicaid-covered services" starting on page 34.

Full benefits means that you are eligible for all services that Medicaid covers if medically necessary. The following individuals may be eligible for full benefits:

- pregnant women,
- children age 20 and under, and
- adults who are blind, age 65 or older or disabled and anyone receiving Supplemental Security Income (SSI).

Basic benefits means that some services are *not* paid for by Medicaid, except in the case of an emergency, or where a job requires the services ("essential for employment" - check with your eligibility case manager). This includes adults receiving Medicaid over age 20 who are:

- not pregnant,
- not blind,
- under age 65, and
- not disabled or receiving SSI.

Examples of services not covered under basic benefits:

- audiology (hearing aid exams and hearing aids)*
- dental services (except emergencies) *
- durable medical equipment and supplies (except for insulin-dependent diabetics, ostomy supplies, home infusion therapy, oxygen, and prosthetics)*
- eyeglasses and routine eye exams*
- personal assistance services*

* These services *may* be covered under basic benefits if they are 'essential for employment' – EFE. Ask your eligibility case manager.

Your responsibility

Know if you have ***full*** or ***basic*** benefits. Understand what these benefits include. Tell your medical provider you have Medicaid and show your Medicaid card at every appointment. *Ask your provider if Medicaid pays for the service or if you are responsible for the bill.*

Cost sharing – What do I have to pay?

You must pay a small amount for many services if you are:

- age 21 or over,
- *not* pregnant*, or
- live outside a nursing home.

Clients age 20 and under *do not* pay cost sharing. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services also do not have cost sharing. See page 32 for more information.

* Medicaid considers pregnancy to last 60 days past the last day of pregnancy and through the end of that month. It is your responsibility to tell your provider that you are pregnant each time you receive services.

- *Cost sharing* means clients will pay either a co-payment or a co-insurance depending on the service.
- A *co-payment* is a set dollar amount that is paid by the client to a health care provider for services.
- *Co-insurance* is a percentage of the Medicaid allowed amount for services that is paid by the client to a healthcare provider.

All Medicaid services require cost sharing except:

- emergency services
- family planning
- home dialysis attendant
- eyeglasses purchased through a volume purchasing agreement
- hospice
- personal assistance
- transportation
- early and periodic screening, diagnostic, and treatment services (EPSDT)
- substance dependency services
- services provided in an IHS facility
- home and community based waiver services (see page 43)

Cost sharing fees:

- For each prescription, cost share will be between $1 and $5, but not more than $25 in one month for all prescriptions.
- Each visit to a provider will be between $1 and $5.
- An inpatient hospital stay (overnight) will be $100.
- There is no yearly cap on cost shares.

If you have another health insurance, such as Medicare or a private insurance that pays for the service, then you have no cost sharing for that service.

The amount of cost share you must pay for a visit depends on how many services you receive – *during that visit. Please see the charts on pages 34 – 41 to determine how much* cost sharing will be for each type of service.

Common Questions & Answers

Q: How much will my cost sharing be for a service?

A: Ask your health care provider. They will know the Medicaid allowed amount for the service and what your share will be.

Q: Do I have to pay a cap for prescription drugs and another cap for other services?

A: No. There is a $25 per month cap on pharmacy services. There are no cost share caps for other services.

Q: What if I cannot pay the cost sharing?

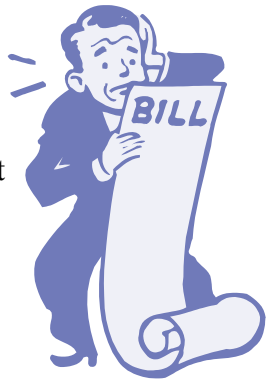
A: You are responsible for paying the cost sharing amount to your provider. If you have questions, ask your provider. Providers may bill clients for unpaid cost shares.

Your account can be turned over to a collection agency for not paying your share of the costs – your 'cost share.' Your health care provider may also end your provider-patient relationship at any time (except mid-treatment) by notifying you.

Medicaid billing information

We encourage you to *work closely with your provider* to solve billing problems! The following information may help you better understand Medicaid claims.

- You are responsible for knowing if you have *full or basic* Medicaid benefits and what is covered.
- Show your Medicaid card at all medical appointments.
- Ask your provider if he or she is a Medicaid provider. If they're not, Medicaid will not pay the claim.
- You are expected to make cost sharing payments unless you or the service you receive are exempt from cost sharing.
- Several cost shares can look like bills for services. Ask your provider if you have questions about a bill.



- Check the date of service on the claim and verify with your eligibility case manager that you were on Medicaid during that time.
- If the provider *accepted you as a Medicaid client*, he or she cannot bill you for that service. Ask your provider if you are accepted as a Medicaid client!
- Your provider can bill you for a service that is not a Medicaid-covered service *if* he or she told you before providing the service that you would be responsible for payment, and you agreed.
- Your provider cannot bill you for the part of a bill that Medicaid does not pay.
- You have the right to ask for an appeal if Medicaid has denied the payment of a claim.
- Often, providers send out a notice of billing to the client and will also send the claim to Medicaid for payment. Call your provider and ask about the bill.
- Your provider cannot stop services in the middle of treatment. Your provider can, however, end your patient-provider relationship at any other time if or she notifies you.
- You must have prior authorization for out-of-state inpatient hospital stays.

Use the Medicaid Services Chart starting on page 34 to check if a service is covered. Call the Medicaid Help Line at 1-800-362-8312 if you have questions.

Limits on covered services

There may be limits on some services. Check with your provider to see if a service is medically necessary.

For adults age 21 and over, there are limits on how many times you may use some services. For more information, be sure to check each service in the "Medicaid Services Chart" starting on page 34.

Important things to remember about your coverage

- Some covered services need a referral or a prescription from your provider or other health care provider.
- Some services require your provider to get approval from Medicaid *before* you receive the service. This is known as "prior authorization."
- Some services are only for clients age 20 and under. Check each service in the "Medicaid Services Chart" starting on page 34.
- For adults age 21 and over, there are limits on some services. Check the Medicaid Services Chart" starting on page 34.
- If you are on the PASSPORT to Health program, you must get an approval from your PASSPORT provider for most services. It is *your* responsibility to request approval *before you get a service.*
- If you do not get your PASSPORT provider's okay for most hospital services and provider visits, Medicaid will *not* pay for them, and you may be responsible for paying the bill. "Emergency" is defined on page 11.
- The Nurse First advice line does not provide authorizations or referrals.
- If you have other health insurance in addition to Medicaid, your other insurance may have rules about getting an okay before receiving some services. Check with them to see what their rules are.
- Some services are not covered under basic Medicaid. Check the "Medicaid Services Chart" starting on page 34.

Other health insurance

If you have other health insurance in addition to Medicaid, or if someone else pays for your medical bills, Medicaid is usually billed last. However, Medicaid should be billed before Indian Health Services and Crime Victim's Compensation. Examples of other health insurance include:

- Medicare;
- private health insurance companies;
- health maintenance organizations (HMOs); or
- anyone else who should pay for your medical costs.

If someone else should pay your bills, tell your eligibility case manager and your provider. If you receive money from another responsible party for medical bills, you must give it to the health care provider.

Health Insurance Premium Payment program

This program pays for Medicaid clients to have another type of health insurance besides Medicaid. Here are some examples of ways you may be eligible for this program:

- you have insurance either through your job or an individual health policy
- your job offers insurance, but you haven't signed up because it costs too much
- you have a new job, and your insurance won't start for awhile
- you had insurance through your job, but you are no longer working and can't afford the insurance.

If you have private insurance, or if private insurance is available to you, please contact your eligibility case manager. Before Medicaid pays your insurance premium, we review health problems in your family and check the cost and coverage of your insurance plan. If your insurance is found to be *"cost effective,"* Medicaid will pay the premium. You will then be covered by both private insurance and Medicaid. You will get a Medicaid card.

For more information about the Premium Payment Program, call 1-800-694-3084.

Estate recovery and liens against property

Some people who get Medicaid have to pay Medicaid back for services that were originally paid by Medicaid. If you go into a nursing home and own real estate, Medicaid may place a lien on the real estate. When the real estate is sold, money from the sale is used to repay Medicaid.

If you have a spouse or legal dependents living in the home, or if the real estate is Indian trust property, a lien will not be placed on the property.

Medicaid will file a claim against the estate of a deceased client who received any benefits after age 54, or who resided in a nursing home or in Home and Community Based Services unless there is a surviving spouse or legal dependent. For more information about estate recovery and liens against property, call 1-888-378-2836.

Who can I see for health care? Where can I go?

Some providers do not accept Medicaid. It is your responsibility to ask if a provider accepts Medicaid *before* you get care.

When you call to make an appointment, ask, "Do you accept Medicaid?" If the provider does not accept Medicaid, you may still be seen by that provider, *but you will be responsible for paying the bill*.

Listed below are examples of common types of providers that you can see for your healthcare and places that you can go for medical services. The provider MUST accept Montana Medicaid in order for Medicaid to pay the bill. If you are in PASSPORT To Health, you must receive services from your PASSPORT provider or get a referral from them to see someone else in order for Medicaid to pay the bill.

Physician services

Physician services may be provided in the physician's office, the client's home, the hospital, in an intermediate care facility, a skilled nursing facility, and in an extended care facility. The following are some examples of physicians:

- family practitioner
- internist
- pediatrician
- obstetrician
- gynecologist

Mid-level practitioners

Mid-level practitioners are licensed physician assistants and advanced practice registered nurses. Advanced practice registered nurses are nurse anesthetists, nurse practitioners, clinical nurse specialists and certified nurse midwives. (Delivery of babies by certified nurse midwives *must* be in a licensed facility.)

Ambulatory surgical center

These centers are for outpatient surgery only. Generally, covered surgical procedures are limited to surgeries that do not exceed ninety minutes of operating time and a total of four hours recovery time.

Federally-Qualified Health Centers (FQHC)

An FQHC may be an outpatient health program operating as a community health center, or an outpatient facility operated by a tribe or tribal organization. Services offered include physician services, physician assistant services, nurse practitioner services, certified nurse midwife services, dental services, preventive care, and primary care services.

Rural Health Clinics (RHC)

An RHC is an outpatient health clinic located in a rural area. Services offered include physician services, physician assistant services, nurse practitioner services, certified nurse midwife services, preventive care, and primary care services.

County Health Departments/ Clinics

Services offered include:

- physician services
- physician assistant services
- nurse practitioners
- certified nurse midwife services
- preventive care
- primary care services

Indian Health Service (IHS)

Services offered include physician services, physician assistant services, nurse practitioner services, certified nurse midwife services, preventive care, and primary care services.

Medicare or private insurance

If you have Medicare, or another insurance in addition to Medicaid, it is *still important* to ask the health care provider if he or she accepts Medicaid.

If the health care provider agrees to accept both your other health insurance and Medicaid, it means they cannot bill you (except for cost shares or co-payments) as long as the service is something Medicaid would normally cover.

If the provider *does not* accept Medicaid, Medicaid cannot pay for the difference between what is billed and what your other insurance will cover. You would then be responsible to pay.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Regular check-ups for your children

Medicaid is your medical insurance – it is available for preventive healthcare as well as for an illness. All children who receive Medicaid are eligible for Well Child services through age 20. These services are called Early and Periodic Screening, Diagnosis, and Treatment services, or EPSDT for short. EPSDT encourages routine check-ups for children, even when they are not sick. *There is no co-payment or cost share required* for EPSDT services and immunizations.

EPSDT services are provided by your child's health care provider and other health professionals (health department, clinic, dentist, etc.) Call for an appointment, and be sure to say you want an EPSDT or Well Child check-up for your child so health care providers can schedule the right amount of time. Take your child's Medicaid card with you.

What is an EPSDT exam?

When you see your health care provider for an EPSDT exam (sometimes called a Well Child check-up), your child or teenager should receive the following checks:

- Head-to-toe physical exam
- Eye exam and hearing check
- Nutrition check
- Growth and development check
- Blood and urine tests
- Immunizations, if needed
- Speech and language check
- At least one visit per year to a dentist after the first tooth comes in

If any problems are found during the check-up, your child will be referred to the right provider for further exams and possible treatment.

When should your child get Well Child check-ups or immunizations (shots)?

Age	Service	Age	Service
Birth to 1 month	Well Child Check & Immunization	**4 years**	Well Child Check Up
2 months	Well Child Check & Immunization	**5 years** (before kindergarten)	Well Child Check & Immunization
4 months	Well Child Check & Immunization	**6 years**	Well Child Check Up
6 months	Well Child Check & Immunization	**8 years**	Well Child Check Up
9 months	Well Child Check Up	**10 years**	Well Child Check Up
12 months	Well Child Check Up	**12 years** (before middle school)	Well Child Check & Immunization
15 months	Well Child Check Up	**14 years**	Well Child Check Up
18 months	Well Child Check Up	**16 years**	Well Child Check Up
2 years	Well Child Check & Immunization	**18 years**	Well Child Check Up
3 years	Well Child Check Up	**20 years**	Well Child Check Up

Immunizations (shots)

It's important to visit your provider, Community Health Center, or County Public Health Department to get the right immunizations (shots) for your child.

Immunizing your child not only protects your child, but all the people they come in contact with. Check with your provider about which shots your child should have. Some common shots to protect against diseases are:

- Hepatitis B
- Diptheria-tetanus-pertussis (combined vaccine)
- H influenza type B
- Polio
- Pneumococcal disease
- Measles-mumps-rubella (combined vaccine)
- Chicken pox and flu.

Please remember:

It's important to keep a record of the immunizations completed by your health care provider – this is an official document and is required for entry to day care centers, schools, and even college. If your child has missed a shot, go to your provider as soon as possible to get it.

Give your child the gift of protection and a record to prove it!

Keep Your Children Healthy

Eat Sensibly. Your kids are forming eating habits that may last a lifetime!

- Choose a wide variety of foods, including plenty of grains (especially whole grains), at least five servings of fruits and vegetables a day, low-fat dairy and lean meat.
- Be a positive role model during meals. Show kids how to enjoy all foods without going overboard on high-fat or sugary foods.
- Let your children decide how much food to eat.
- Make sure kids have easy access to fresh fruit, vegetable snacks, and nuts!
- Make water your drink of choice – skip the soft drinks. Offer 1% or skim milk with meals and 100 % fruit juice no more than once or twice a day.

Be active. Plan outdoor activities for your family!

- Aim for at least 30 minutes a day of moderate activity.
- Plan family activities—like hiking, biking, or playing in the park.
- Take advantage of every opportunity to add exercise to your life—take the stairs instead of the elevator, choose active and fun hobbies, walk the dog every day.
- Do something fun and fit every day to increase your health and your children's health!

Aim for a healthy weight. Balance what you eat with your activity level.

Medicaid Services Chart

- **Services must be medically necessary to be paid for by Medicaid.**
- **It's your responsibility to understand if you are covered under *full* or *basic* benefits, and to know what services are available based on the lists in this chart.**
- **Not all Medicaid services are listed.**
- **The services you may be eligible for can change. If you are in the Home and Community Based Waiver program, or are receiving Developmental Disabilities Services, there may be differences as well.**
- **All Medicaid services are available to those age 20 and under if medically necessary.**

Medicaid Services	Full Benefits Does full Medicaid cover this service?	Basic Benefits Does basic Medicaid cover this service?	PASSPORT Approval If you are on PASSPORT, is a referral from your PASSPORT provider needed before getting service?	Cost Share Is there a cost share for this service? *Note*— Pregnant women and children under age 20 do not pay cost share.	Prior Authorization Some services require your provider to get prior approval from Medicaid. Check with your provider.
Abortion	Ask your provider. Some abortions are covered.	Ask your provider. Some abortions are covered.	No	No	No
Ambulance Emergency ground and air transport. (See 'Transportation non-emergencies; definition of an emergency page 10.)	Yes	Yes	No	No	Providers must notify of unscheduled transport.
Anesthesiology	Yes	Yes	No	$4	No
Blood Lead Testing	Yes	Yes	No	$4	No
Case Management – Targeted	Yes	Yes	No	No	No
Chiropractic	Only for those age 20 and under, or with QMB co-insurance. See page 60	No	Yes	No	No

Medicaid Services	Full Benefits	Basic Benefits	PASSPORT Approval	Cost Share	Prior Authorization
Circumcision	Yes	Yes	Yes	$4	Yes
Dental	Covered for an oral exam and cleaning every 6 months; limits on most other services. Ask your dentist.	No	No	$3	Some services have limits. Ask your dentist.
Developmental Disabilities Services	Yes - Ask your provider if you qualify. There is a waiting list.	Yes - Ask your provider if you qualify. There is a waiting list.	No	No	Eligibility criteria must be met. See page 60.
Dialysis – Free Standing Centers	Yes	Yes	No	$5	No
Dialysis - Home Dialysis Attendant Service	Yes	Yes	No	No	Yes – Approval of home attendant.
Drugs - Prescription	Yes—There are some limits. Ask your provider.	Yes—There are some limits. Ask your provider.	No	$1 to $5 for each prescription, but never more than $25 in one month.	Some prescriptions require prior authorization. Ask your provider.
Durable Medical Equipment – Orthotic, Prosthetic and Supply	Yes	Might be covered if the equipment is needed to get a job or keep a job. * EFE - Check with your provider.	No	$5 for each item.	Some services require prior authorization. Ask your provider.
Emergency Room See detailed list of services, page 46, for more information.	***Emergencies only***. You may have to pay for non-emergencies even if you have a referral.	***Emergencies only***. You may have to pay for non emergencies even if you have a referral.	No.	Not for emergency services. All other services have a cost share.	No

* EFE means *Essential For Employment:* This service **may** be covered under BASIC benefits if it is 'essential for employment.' Ask your eligibility case manager.

Medicaid Services	Full Benefits	Basic Benefits	PASSPORT Approval	Cost Share	Prior Authorization
Eye Exams	Age 21 and older: 1 exam every 24 months. Age 20 and under: 1 exam every 12 months. Covered for eye disease or injury.	Covered for eye disease or injury. Might be covered if needed to get a job or keep a job. Ask your Eligibility Case Manager.	No	$2	No
Eyeglasses	One pair every 24 months for age 21 and older. One pair every 12 months for clients age 20 and under.	Might be covered if needed to get a job or keep job. Ask your Eligibility Case Manager.* EFE	No	You might pay a $2 cost share to an optician.	No
Family Planning Some services include: reproductive health exams, client counseling and education, sterilizations, testing for sexually transmitted diseases, and birth control supplies.	Yes	Yes	No	No	No—Some services like sterilization have additional requirements. Ask your provider about specific services.
Hearing Aids	Yes	Might be covered if needed to get a job or keep a job. Ask your Eligibility Case Manager. * EFE	No	$2 for each hearing aid.	Yes
Hearing Exams	Yes	Might be covered if needed to get a job or keep a job. Ask your Eligibility Case Manager. * EFE	No	$2	No

* EFE means *Essential For Employment:* This service **may** be covered under BASIC benefits if it is 'essential for employment.' Ask your eligibility case manager.

Medicaid Services	Full Benefits	Basic Benefits	PASSPORT Approval	Cost Share	Prior Authorization
Home and Community Based Waiver Services Ask your Eligibility Case Manager about qualifying for these special services.	Yes—there is a waiting list and you must qualify for services	Yes—there is a waiting list and you must qualify for services	No	No	Yes—See list of detailed services, page 45, for more information.
Home Health Services See page 46 for a list of detailed services.	Yes	Yes	Yes	$3	Yes
Home Infusion Therapy	Yes	No	No	$5	Yes, for some services.
Hospice	Yes	Yes	No	No	No
Hospital – Inpatient See page 46 for details on out-of-state Hospital coverage.	Yes	Yes	Yes—except for pregnancy related.	$100 per stay.	Yes, for some services.
Hospital – Outpatient See page 47 for details on out-of-state hospital coverage.	Yes	Yes	Yes, except family planning, pregnancy related services, shots, vision, dental, and certain others. Ask your provider.	$5	Yes, for some services. Ask your provider.
Hospital—Nursing Home Care (Swing Beds)	Yes - A *swing* bed is when you stay in the hospital and are waiting for a bed to be open in a nursing home.	Yes	No	No	Yes, for some services. Ask your provider.
Immunizations (shots)	Yes	Yes	No	No	No
Lab	Yes	Yes	No	$4 if done by your provider.	No

Medicaid Services	Full Benefits	Basic Benefits	PASSPORT Approval	Cost Share	Prior Authorization
Mental Health Services	Yes	Yes	No	Yes, for some services. Ask your provider.	Some services Ask your provider.
Nursing Homes	Yes	Yes	No	No	Some services require prior authorization. Ask your provider.
Nursing Services; Intermediate Care Facilities for the mentally retarded	Yes	Yes	No	No	Some services require prior authorization. Ask your provider.
Nutrition Services	Only for those age 20 and under. Diabetic nutrition education may be covered for adults.	Diabetic nutritional education may be covered for adults. Ask your provider.	Yes	No	No
Obstetric Services (OB) Pregnancy and childbirth	Yes	Yes	No	No	No
Occupational Therapy - Outpatient/ Private Practitioner (Ask your provider about limits.)	Yes - Those 21 and older are limited to 40 hours per year from July 1 - June 30	Yes - Limited to 40 hours per year from July 1 to June 30.	Yes	$5 for outpatient. $2 for private practitioner	Yes, *if over limits*, for those for those age 20 and under. For private practitioners: no
Orthodontia	Yes for eligible children age 20 and under that meet criteria.	No	No	No	Yes
Personal Assistance Services Assistance for daily living activities.	Yes	Might be covered if needed to get a job or keep a job (EFE). Ask your Eligibility Case Manager.	No	No	Yes

Medicaid Services	Full Benefits	Basic Benefits	PASSPORT Approval	Cost Share	Prior Authorization
Physical Therapy - Outpatient/ Private Practitioner (Ask your provider about limits)	Yes - Those 21 and older are limited to 40 hours per year from July 1 to June 30	Yes - Limited to 40 hours per year from July 1 to June 30.	Yes	$5 for outpatient. $2 for private practitioner.	No, if within limits. *Yes, if over limits*, and age 20 or under. For private practitioners: no
Physician Services	Yes—Most services are covered. Ask your provider.	Yes—Most services are covered. Ask your provider.	Yes, except family planning, Pregnancy-related and mental health services, shots, vision, dental, and certain others.	$4	Some services require prior authorization. Ask your provider.
Podiatry	Yes	Yes	No	$4	No
Private Duty Nursing	Only for those age 20 and under with severe medical problems.	No	Yes	No	Yes
Respiratory Therapy	Only for those age 20 and under.	No	Yes	No	No
School-Based Services	Only for those age 20 and under.	No	Some services require PASSPORT approval.	No	Yes for private duty nursing.
Social Worker Services (Licensed)	Yes	Yes	No	$3	No
Speech Therapy - Outpatient/ Private Practitioner (Ask your provider about limits.)	People age 21 and older are limited to 40 hours/year from July 1 to June 30.	Limited to 40 hours per year from July 1 to June 30	Yes	$5 for outpatient. $3 for private practitioner.	No, if within limits. *Yes, if over limits*, and age 20 or under. For private practitioners: no
Substance Dependency Services—Day Treatment (No over-night stay) State ap-proved, non-hospital facility for alcohol and other drugs.	For those age 20 and under only - must complete substance dependency inpatient treatment.	No	No	No	Yes

Medicaid Services	Full Benefits	Basic Benefits	PASSPORT Approval	Cost Share	Prior Authorization
Substance Dependency Services—Non-Hospital Inpatient State approved, non hospital facility for alcohol and other drugs.	Yes—Covered for clients age 20 and under only.	No	No	No	Yes
Substance Dependency Services—Non-Hospital Outpatient State approved, non hospital facility for alcohol and other drugs.	Yes	Yes	No	No	No
Surgery—In-State Outpatient	Yes	Yes	Yes	$5 each time.	For some services—ask your provider.
Swing Bed Services—In Hospital	Yes	Yes	No	No	Some services require prior authorization. Ask your provider.
Therapeutic Family (Foster) Care Services	Yes—For clients age 20 and under only.	No	No	No	Yes
Therapeutic Group Home Care Services	Only for those age 20 and under.	No	No	No	Yes
Therapy—Outpatient Occupational/ Physical/Speech (Ask your provider about limits.)	People age 21 and older are limited to 40 hours per year from July 1 to June 30	Limited to 40 hours per year from July 1 to June 30	Yes	$3 each visit for speech therapy. $2 each visit for occupational and physical therapy.	No—if within limits. Yes—if over limits. Ask your provider.

Medicaid Services	Full Benefits	Basic Benefits	PASSPORT Approval	Cost Share	Prior Authorization
Tobacco - Products to help you stop smoking or chewing tobacco	Yes	Yes	No	$1 to $5 for each prescription.	Some drugs or patches require prior authorization or have limits. Ask your provider.
Transplants Clients age 21 and older are limited to kidney, cornea, and bone marrow transplants for certain conditions and if medically necessary.	Yes—Clients age 20 and under are covered for medically necessary non-experimental transplants.	Yes - Clients age 20 and under are covered for medically necessary non-experimental transplants.	Yes	For people age 21 and older, $100 for each stay in the hospital.	Yes
Transportation—non-emergency and *per diem* For the least costly form of transportation to get necessary covered services closest to you when there is no other way to pay for transportation. See list, page 52.)	Yes - Call 1-800-292-7114 before you travel.	Yes - Call 1-800-292-7114 before you travel.	No	No	Call Medicaid Transportation 1-800-292-7114
Well Child check-ups	Yes - For those age 20 and under.	No	Yes	No	No
X-Rays	Yes	Yes	No	Yes, for some services. Ask your provider.	No

Call the Montana Medicaid Help Line if you have questions or need more information. The toll-free number is 1-800-362-8312. Please have your social security number or Montana 'Access to Health' card number ready before you call.

Detailed list of some Medicaid-covered services

This list includes examples of covered Medicaid services. Not all services are listed, and not all details about a service are shown. Ask your health care provider, or call the Medicaid Help Line, 1-800-362-8312, for more information.

Abortion

Abortion is only covered if:

- It is necessary to save the mother's life.
- The pregnancy was caused by an act of rape or incest.
- Your provider puts in writing that even though the woman's life is not in danger, it is medically necessary.

Ambulance

Emergency ambulance services are covered for emergency ground or air transports. Call 911 or your local emergency number for services. An emergency means the symptoms of the medical condition seem so severe that a prudent layperson (a person with average knowledge of health and medicine) would expect that there might be danger to the health of the individual unless the symptoms were treated immediately. (See Transportation for more information.) If it is not an emergency, Medicaid will not pay.

Birth control—see Family Planning

Case management (targeted)

Medicaid may cover the cost of targeted case management, which is planning and help in getting medical, social, educational, nutritional, and other Medicaid-covered services. This service is for people in the following groups:

- high-risk pregnant women and their babies through one year of life;
- people 18 and older with severe and disabling mental illness;
- people 16 and older with developmental disabilities;
- severely emotionally disturbed children;
- children at risk for abuse and neglect;
- children with special health care needs; and
- children age 20 and under with substance dependency or abuse.

Chiropractic services - EPSDT and QMB service only* (full benefits only)

Chiropractic services are covered for children age 20 and under. Adults *are not* eligible, even if they have full benefits*, unless they receive QMB and Medicare pays on the chiropractic service.* Medicaid will pay the Medicare premiums, coinsurance, and deductibles for *only* those adults eligible for QMB—see page 62.

Covered services for children age 20 and under include:

- spine adjustment;
- limited X-rays; and
- evaluation and management.

If you are in PASSPORT, this service requires PASSPORT provider authorization.

***EPSDT Service—**Early and periodic screening, diagnosis and treatment (EPSDT) services are only offered to children age 20 and under.

Dental Services, including services provided by denturists (full benefits only)

Covered services include most routine dental care, such as exams and cleanings for adults every six months and as often as necessary for children. Some full benefit services are only available to those age 20 and under, like bridges and tooth-colored crowns. Check with your provider. Adults on full benefits are limited to prefabricated stainless steel and resin crowns. Dentures are covered for all ages on full benefits. Partial dentures paid by Medicaid may only be replaced if five years or older. Full dentures paid by Medicaid may be replaced if 10 years or older and are limited to one lost pair in a lifetime.

Orthodontia services are not offered for cosmetic reasons. Orthodontia services are available to those age 20 and under only as part of treatment for certain medical conditions. Other orthodontia services are only available to age 12 and under with posterior crossbite with shift or anterior crossbite. All orthodontia services must have prior authorization; check with your provider.

Dental services (basic benefits)

Dental services are not covered for adults on basic except:

1) When dental services are necessary to seek or maintain employment. Talk with your eligibility case manager about the Essentials for Employment program. Exams, x-rays, and cleanings are not covered under this program. Other services are covered if covered under full benefits.
2) Emergency dental care is covered only when related to emergency treatment. No routine dental services are covered.

Developmental disabilities services

Eligibility criteria for specific services must be met. There is a waiting list for services, and clients must meet level-of-care requirements for specific services. See page 60.

Dialysis

Those suffering from chronic end-stage renal disease may be able to receive these services:

Dialysis clinics (free-standing centers)

- outpatient dialysis;
- training for self-dialysis; and
- home dialysis.

Home dialysis attendant service

- Covered services include payment for trained nurses to assist with home dialysis. This service is given only if you have terminal kidney disease and only when there is no family member who can be trained to help with the dialysis.

Drugs—prescription

Covered services include most approved prescription drugs. Medicaid requires generic drugs when possible. Some drugs may require prior authorization from Medicaid. Medicaid covers the following over-the-counter products *when prescribed*: aspirin, insulin, laxatives, antacids, head lice treatment, H2 antagonist GI products such as Zantac®, proton pump inhibitors such as Prilosec OTC®, non-sedating antihistamines such as *Claritin*®, and bronchosaline. Nursing facilities are responsible for providing over-the-counter laxatives, antacids and aspirin to their residents. Discuss all medications with your provider.

Durable medical equipment—orthotic, prosthetic and supply (full benefits only*)

Coverage and limits are based on medically necessary items delivered in the most appropriate and cost effective manner. Some services require prior authorization from Medicaid, so ask your medical provider. Basic benefits cover services only as an exception.

Emergency room—see Hospital Services

Emergency means symptoms of the medical condition seem so severe that a prudent layperson (a person with average knowledge of health and medicine) would expect that there might be danger to the health of the individual unless the symptoms are treated immediately. Emergency care treats symptoms that threaten life or might cause permanent damage.

Eye exams—optometric services/ophthalmologic services (full benefits only*)

Covered services include:

- one eye exam every 24 months for adults age 21 and over; unless vision changes significantly, or for treatment of eye disease.
- one eye exam every 12 months for children age 20 and under; unless vision changes significantly, or for treatment of eye disease.

- This service **may** be covered under BASIC benefits if 'essential for employment.' Ask your case manager.

Eyeglasses (full benefits only*)

Covered services include one pair of eyeglasses every 24 months for those age 21 and up (unless there is a major change in your prescription or you have had cataract surgery) or every 12 months for those clients age 20 and under. You must select frames approved by Medicaid, or you may pay for frames yourself. Frames paid for by Medicaid have a 24-month warranty. Medicaid does not pay for most add ons, such as photo-grey lenses. Adults age 21 and over will be responsible for any add-ons. Medicaid may pay for add-ons that are medically necessary for children age 20 and under.

Family planning

Some covered services include (but are not limited to):

- physical exams with breast exams
- pap smear (to test for pre-cancerous conditions)
- pregnancy testing
- birth control: pills, Norplant, condoms, Depo Provera shots, and most other types of family planning supplies
- sexual health counseling (how to prevent unwanted pregnancy and sexually transmitted diseases)
- testing and treatment for sexually transmitted diseases
- shots for German measles
- sterilization information and counseling is covered (for mentally competent persons 21 years old and over) if a consent form is signed by the patient at least 30 days before the scheduled sterilization.

Infertility treatment and paternity tests *are not* covered.

Hearing aids (full benefits only*)

Covered services include hearing aids, repairs, and certain related items and must be ordered by your provider. The person who sells the hearing aid must get approval from Medicaid.

Hearing exams—audiology (full benefits only*)

This service is covered when provided by a **licensed** audiologist and ordered by your health care provider.

Home and community-based waiver services

This program serves people in the community who would otherwise need nursing home or hospital care. Services must be ordered by your health care professional and you must be determined eligible. (This program, HCBS, is also called *"Medicaid waiver."*)

You must meet the criteria for level of care. You also must be assessed and approved by a case management team and a space must be available in the program. Those enrolled in the Medicaid Home and Community Based Services Program are eligible for a special set of services that may not be listed here, in addition to their full or basic benefits.

Here is a partial list of HCBS services: Case management, personal assistance for supervision and socialization, modifications to home or vehicle, supported living, assisted living, homemaking, private duty nursing, special services for people with brain injury, service dogs, Meals on Wheels, respite, and habilitation.

* These services *may* be covered under basic benefits if 'essential for employment.' Ask your eligibility case manager.

Home Health services

These covered services are technical and skilled. The services must be provided by a licensed and certified agency. Covered services include:

- Part-time care in your home from a skilled nursing service;
- home health aide care—services to assist in the activities of daily living and care of the household to maintain the client in their home for a short, definite period of time;
- physical therapist, occupational therapist, or speech therapist
- medical supplies and equipment suitable for home use.

To receive services:

- Most services must be ordered by your health care professional;
- The home must be an appropriate place to deliver care or you are unable to get the services anywhere else except from a home health agency; and
- If you are age 21 or over and you need home health aide services, the home health agency has to get approval from Medicaid.

If you are age 21 or over, there is a limit of up to 100 visits in your home for physical, occupational, or speech therapy per fiscal year. For nursing services, the limit is 75 visits per fiscal year. Check with your provider.

Home infusion therapy (full benefits only*)

Some drug treatments must be given intravenously. For some people, these treatments may be provided safely in their homes. Drugs given intravenously in the home must be dispensed by a licensed pharmacy. These treatments are called "home infusion therapy."

Hospice

Hospice is comfort care for terminally ill people. Hospice manages all care related to the terminal illness. Grief counseling is also available to the family. An illness is terminal when the provider certifies that the patient is expected to die within six months.

Hospital services

Emergency room services

Covered services include emergency care. An emergency means symptoms seem so severe that a prudent layperson (a person with average knowledge of health and medicine) would expect that there might be danger to the health of the individual unless the symptoms were treated immediately. *Emergency care* is treating symptoms that threaten life or might cause permanent damage. *Urgent care* is care for health problems that are not life-threatening, but serious enough that you should get help quickly.

Hospital inpatient services (including surgery—inpatient)

Inpatient hospital services are hospital stays where the primary care provider has admitted you to the hospital. Covered services include those offered by a hospital, which must be medically necessary. Some services require prior approval from Medicaid. All services are subject to review by Medicaid.

Inpatient hospital services provided outside 100 miles of the Montana border must be pre-authorized for planned procedures and authorized within 48 hours of emergency services. See page 55, Out-of-state Medicaid coverage, for information.

Hospital Services (continued)

Hospital outpatient services

Outpatient hospital services are services provided in a hospital setting where the primary care provider has *not* admitted you as an inpatient. Covered services are emergency room services and other services, including but not limited to: physical therapy, occupational therapy, speech-language pathology, dialysis, lab, and x-ray.

Medicaid does *not* cover cardiac (heart) or pulmonary rehabilitation, education or exercise programs. Some services require pre-approval from Medicaid and all services are subject to review. See page 55, Out-of-state coverage, for information.

Immunizations (shots)

Immunizations to protect from diseases are covered. Well Child Check Ups for children include the necessary immunizations. See EPSDT information on page 32.

Lab

Lab services are covered by Medicaid as long as the services are medically necessary and ordered by your provider. Talk with your medical provider to make sure the lab accepts Montana Medicaid, or you may be responsible for the bill.

Medical supplies and equipment—see Durable medical equipment

Mental health services; adults—both inpatient and outpatient

- Crisis and emergency services
- Individual group and family counseling
- Case management
- Day treatment services
- Inpatient treatment

Mental health services; children

- Crisis and emergency services
- Individual, group, and family counseling
- Case management
- Day treatment
- Psychological testing
- Community based psychiatric rehabilitation and support (individual and group)
- Comprehensive school and community treatment
- Therapeutic group and family care
- Inpatient psychiatric hospital service
- Inpatient psychiatric residential treatment

If you are found not eligible for Medicaid, and are within 150 percent of federal poverty guidelines, you may qualify for the Children's Mental Health Services Plan (CMHSP). Call 1-877-543-7669 for an application or (406) 444-4540 for information.

Nursing Homes

Covered services include a semi-private room (private room if deemed medically necessary), laundry (except dry-cleaning), travel for local doctor appointments, meal service, minor medical or surgical supplies, nursing and other health services, nursing rehabilitation services, social services, and activity programs ordered by your provider. The nursing home will likely provide you a more detailed list of services that are covered. Some services require prior authorization.

Nursing services in intermediate care facilities—for the mentally retarded

Nursing facility or intermediate care facility services for the mentally retarded are covered, including use of facility, equipment, and a medically-necessary room, general nursing services, dietary services and other items routinely provided to residents.

Nutrition services - EPSDT service only* (full benefits only)

Covered services include evaluation and treatment by a licensed nutritionist or registered dietitian. Medicaid will cover medical foods and/or special nutritional supplements to children age 20 and under who have a diagnosed medical condition that restricts the use of some or all conventional foods. A primary care provider's order, a certificate of medical necessity, is needed to get the supplements. Supplements can be obtained through durable medical equipment suppliers who carry supplemental food products. If you are in PASSPORT, nutrition services require authorization. Diabetic nutritional education may be covered for adults. Ask your provider.

Obstetric Services (OB)

OB care includes all prenatal visits, delivery, and six-week postpartum check ups for the mother. Delivery of babies by certified nurse midwives must be in a licensed facility.

Occupational therapy—outpatient (see therapies)

Orthodontia (full benefits only)

Services are covered for those age 20 and under who meet certain qualifications. The services must be medically necessary and pre-authorized by Medicaid. Talk to your dentist or orthodontist.

Personal assistance services (full benefits only**)

Services must be ordered by your health care professional, supervised by a nurse when necessary, and provided by a personal care attendant employed by an enrolled agency. Services are limited to 40 hours per week. Personal assistance services are not covered while you are in a hospital or nursing home. Covered services include help with activities of daily living, such as:

- bathing and dressing
- using the toilet
- walking
- fixing meals and eating
- giving yourself medication

Covered household duties must be directly related to your medical needs and be a part of your care plan. No more than one-third of the time for personal assistance services can be spent on household duties. If you are getting services from home health aide services, you can't get personal assistance attendant services. Household duties include:

- cleaning the area you use
- changing your bed and doing your laundry
- shopping for your groceries

- EPSDT Service—Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are only offered to children age 20 and under.

** This service **may** be covered under basic benefits if 'essential for employment.' Ask your eligibility case manager.

Physical therapy - outpatient (see Therapies)

Physician services

Most physician services are covered. Examples of covered services include:

- delivering babies
- treating high blood pressure
- office visits
- physicals
- surgeries
- giving immunizations

Sterilization is covered if a consent form is signed at least 30 days prior to the procedure—the person must be mentally competent and 21 years old at the time he/she signs the consent form.

Abortion is covered in situations defined by law. (For more information, see abortion listing earlier in this section)

Examples of services *not* covered include:

- infertility treatment
- routine circumcision
- gastric bypass ("stomach stapling")
- cosmetic services, unless the provider proves possible harm to your well-being and gets prior approval from Medicaid.

Podiatry (foot care)

Covered services include:

- cutting or removing corns or calluses,
- trimming nails,
- applying skin creams,
- measuring and fitting foot and ankle devices, and
- lab services and supplies.

Orthopedic shoes are covered if you are age 20 and under, or there is a brace or an orthopedic device *attached to the shoe.*

Private Duty Nursing (full benefits—EPSDT service only*)

For children age 20 and under with severe medical problems, covered services include skilled nursing services performed by nurses outside of a hospital. Services must be ordered by your provider and authorized by Medicaid. If you are in PASSPORT, this service requires PASSPORT provider authorization.

Services not covered include respite care—taking care of a child to give the regular caretaker a break.

Respiratory Therapy (full benefits—EPSDT service only*)

Respiratory therapy is available only to those age 20 and under. Covered services include treatment evaluations by a licensed respiratory therapist. Services must be ordered by your provider. If you're in PASSPORT, this service requires authorization.

* **EPSDT Service**—Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are only offered to children age 20 and under.

School-Based Services - EPSDT service only* (full benefits only)

School-based services are available only to children age 20 and under. Covered services include:

- speech therapy
- occupational therapy
- physical therapy
- immunizations
- private duty nursing
- para-professional assistance with activities of daily living
- specialized transportation
- comprehensive school and community treatment (CSCT) services
- mental health services at school

Please note: There is not a limit to the number of times a child receives services, as long as the services are medically necessary. If you are in PASSPORT, these services may require PASSPORT provider authorization.

Social Worker services (licensed)

Services for the treatment of mental illness may be covered if medically necessary and provided by a licensed clinical social worker. Services may include individual, group, or family therapy. If your therapist determines that you need more than 24 sessions, authorization is required.

Speech Therapy—outpatient (see Therapies)

Substance dependency services—alcohol and other drugs

Day treatment—no overnight stay (full benefits only)

Covered for clients age 20 and under *only*. Client must have completed *inpatient* substance dependency treatment (described below) and the service must be medically necessary. Services must be ordered by a licensed addiction counselor and provided by a chemical dependency program approved by the state. Prior authorization is required. Medicaid does not pay for out-of-state treatment. (Non-hospital)

Inpatient treatment (full benefits only)

The service must be determined medically necessary for the client. The service is a 24-hours-a-day, 7-day-a-week service to the patient living within the facility. Covered services include inpatient help with drug or alcohol addiction. Services must be ordered by a licensed addiction counselor and provided by a chemical dependency program approved by the State. Prior authorization is required. Medicaid does not pay for out-of-state treatment. (Non-hospital)

*** EPSDT Service**—Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are only offered to those age 20 and under.

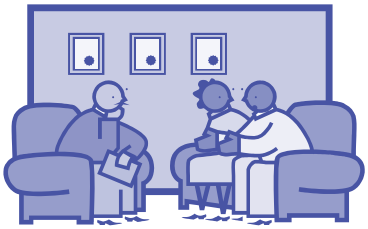
Substance dependency services - alcohol and other drugs (continued)

Outpatient treatment

Covered for clients age 21 and over with a substance dependency diagnosis and for clients age 20 and under with a substance dependency or abuse diagnosis. This service must be determined medically necessary for the client. Services must be ordered by a licensed addiction counselor employed by a State-approved chemical dependency outpatient program under contract with the state. Medicaid does not pay for out-of-state treatment. (Non-hospital)

The following outpatient services are covered:

- Assessment (to find out if you are dependent on alcohol or drugs), limited to one per year
- Individual counseling
- Group counseling
- Family counseling
- Multi-family counseling
- Case management for youth



Surgery, inpatient - see Hospital services

Surgery, outpatient

Covered services include most surgeries at outpatient surgery centers, whether the center is part of a hospital or not.

Swing beds - in hospital

Also called “hospital nursing home bed.” Medicaid will cover nursing home services in hospitals that have "swing" beds when no beds are otherwise available in a nursing home within 25 miles of the hospital. You must meet nursing home admission requirements and you will be transferred to a nursing home when space becomes available.

Therapeutic Group Home care- EPSDT Service only* (full benefits only)

Medicaid pays for the therapeutic portion of group home treatment for children age 20 and under with a serious emotional disturbance. Services must be ordered by your provider, clinical psychologist, licensed social worker, or licensed professional counselor and authorized by Medicaid.

Therapeutic Family services - foster care - EPSDT Service only* (full benefits only)

Medicaid pays for the therapeutic portion of family/foster care for children age 20 and under with a serious emotional disturbance. Services must be ordered by your provider, clinical psychologist, licensed social worker, or licensed professional counselor, and authorized by Medicaid.

*** EPSDT service—**Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are only offered to children age 20 and under.

Therapies

Occupational therapy - outpatient

Covered services include outpatient occupational therapy. Services must be ordered by your doctor or mid-level practitioner. The occupational therapy services must be restorative (improves function).

If you are 21 or older and the occupational therapist you see does not work for a hospital, you are limited to 40 hours of therapy per fiscal year (July 1 to June 30). Therapy can also be covered as part of an in-patient hospital stay and the hospital will bill for it.

Physical therapy - outpatient

Covered services include outpatient physical therapy. Services must be ordered by your doctor or mid-level practitioner. The physical therapy services must be restorative (improves function). If you are age 21 or older and the physical therapist you are seeing does not work for a hospital, you are limited to 40 hours of therapy per fiscal year of therapy (July 1 to June 30). Therapy can also be covered in an inpatient hospital stay and the hospital will bill for it.

Speech therapy - outpatient

Covered services include outpatient speech therapy. Services must be ordered by your doctor or mid-level practitioner. The speech therapy services must be restorative (improves function). If you are age 21 or over and the speech therapist you are seeing does not work for a hospital, you are limited to 40 therapy visits per fiscal year of therapy (July 1 to June 30). Therapy can also be covered in an inpatient hospital stay and the hospital will bill for it.

Tobacco (stop smoking products)

Medicaid pays for many stop smoking products. Ask your provider what services are be covered. Call the Medicaid Help Line at 1-800-362-8312 for more information.

Transplants

Transplant services for adults age 21 and older are limited to kidney, cornea, and bone marrow for certain conditions and if medically necessary. Most transplants are covered for children age 20 and under if medically necessary. All transplant services require prior authorization.

Transportation

Medicaid transportation covers only necessary Medicaid-covered services to the *closest* available provider. It is limited to the least-costly means for your needs, and is available only if you have no other way of paying for transportation to the appointment. Prior authorization is required - call the Medicaid Transportation Center at 1-800-292-7114. You must also call for prior authorization if your trip has been changed or rescheduled. (Transportation continued on next page.)

Commercial Transportation

- Commercial air carrier or commercial ground carrier
- Taxicab or bus
- Prior authorization is required - call the Medicaid Transportation Center at 1-800-292-7114.

Wheelchair vans or stretcher vans

Individuals must have a disability or physical limitation that prohibits their use of usual forms of transportation.

- Vehicle specially equipped to transport people with a disability
- Services provided by a company that maintains a Class B Public Service Commission License or proof of waiver
- Wheelchair van or stretcher van
- Prior authorization is required - call the Medicaid Transportation Center at 1-800-292-7114.

Travel reimbursement

- Travel mileage funds are provided to the owner of the private vehicle used for transportation.
- Travel funds may not be available for travel within your community.
- Travel funds are provided for transportation to the closest available provider.
- Travel funds are for the least costly means of transportation available.
- Travel funds are provided for medically necessary appointments only.
- Payment is usually made after Medicaid verifies that the appointment was kept.
- Prior authorization is required - call the Medicaid Transportation Center at 1-800-292-7114.

Ambulance Services

- Services are covered for emergency care.
- Ambulance must be a licensed by the State.
- Call 911 or the local emergency number
- Covered services include emergency ground and air ambulance transports.
- *Medicaid will not pay for* an ambulance charge when used for non-emergencies.

Non-emergency ambulance services - *scheduled* ambulance trips

- Prior notification and authorization is required.
- Patient must be stretcher-bound.
- *Must* be arranged in advance.
- Must be ordered by a medical provider.
- Prior authorization is required - call the Medicaid Transportation Center at 1-800-292-7114.

Non-emergency ambulance service - *non-scheduled* ambulance trips

- Non-emergency ambulance transports that could not be anticipated or planned during regular business hours; for example, calls to meet a flight team at the airport, after-hours transfers to more acute hospital settings, or one-way returns to nursing homes following transport to emergency rooms.
- Prior authorization is required - call 1-800-292-7114.

An emergency means the symptoms of the medical condition seem so severe that a prudent layperson (a person with average knowledge of health and medicine) would expect that there might be danger to the health of the individual unless the symptoms were treated immediately.

Well Child check-ups — EPSDT Service Only* (full benefits only)

Covered services include check-ups and services for children age 20 and under to find and treat physical illness, mental illness, or disabilities. See the chart below for a schedule of Well Child Check Ups. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are only offered to children age 20 and under.

Age	Service	Age	Service
Birth to 1 month	Well Child Check & Immunization	**4 years**	Well Child Check Up
2 months	Well Child Check & Immunization	**5 years** (before kindergarten)	Well Child Check & Immunization
4 months	Well Child Check & Immunization	**6 years**	Well Child Check Up
6 months	Well Child Check & Immunization	**8 years**	Well Child Check Up
9 months	Well Child Check Up	**10 years**	Well Child Check Up
12 months	Well Child Check Up	**12 years** (before middle school)	Well Child Check & Immunization
15 months	Well Child Check Up	**14 years**	Well Child Check Up
18 months	Well Child Check Up	**16 years**	Well Child Check Up
2 years	Well Child Check & Immunization	**18 years**	Well Child Check Up
3 years	Well Child Check Up	**20 years**	Well Child Check Up

X-Rays

X-rays are covered by Medicaid as long as they are medically necessary and ordered by your medical provider. The provider who does the x-rays must be a provider who accepts Montana Medicaid.

Call the **Montana Medicaid Help Line** if you have any questions or need more information about covered services. The toll-free Help Line number is 1-800-362-8312.

Out-of-state Medicaid coverage

What if you need medical services while out of state?

- A facility located within 100 miles outside the Montana state border is considered in-state. Any facility located more than 100 miles outside the border of Montana is considered out-of-state.
- Providers must get prior authorization from the Mountain-Pacific Quality Health Foundation for ***all*** out-of-state hospital services. Inpatient admission due to an emergency must be authorized within 48 hours; planned inpatient admissions must get *prior* authorization.
- Medicaid will cover out-of-state medical emergency services if the provider accepts Montana Medicaid. (See definition of an emergency on page 46.) A referral from your PASSPORT To Health provider is not needed for the emergency treatment unless you are *admitted as an inpatient* to the hospital.
- If your condition is not life threatening or emergent and you are on the PASSPORT To Health program, you must have a referral from your PASSPORT provider before receiving care.
- You must pay the same cost share for out-of-state services as in-state services.
- You must seek care from a provider who accepts *Montana* Medicaid for payment. If the out-of-state provider does not accept Montana Medicaid, you will have to pay the bill.
- Medical services may be covered for children who live out-of-state for adoption assistance or foster care.

What if the service you need is not available in Montana?

If the service you need is not available in Montana (or within 100 miles of the Montana border), you may get the service out-of-state, as long as the provider accepts Montana Medicaid.

What if you go to an out-of-state nursing home or other long-term care facility?

Your coverage will be the same as in-state coverage. Out-of-state nursing home placements require pre-approval from Medicaid. Services must be short-term or not available in Montana and ordered by your provider. The facility must be willing to enroll as a Montana Medicaid provider or be certified by Montana Medicaid.

Remember! Services in Canada, Mexico, and anywhere outside the United States are never covered.

Services which are *not* covered

Am I responsible for a non-covered service under Medicaid? *Yes.*

- There are limits to some services in Medicaid.
- Check with your provider about limits and ask which services are covered.
- Make sure you know which benefits are covered before you receive medical services.
- You are responsible for keeping track of the services you receive.

Some examples of services which Medicaid will not pay for:

- acupuncture, bio-feedback
- car repair or altering *
- chiropractor services for those age 21 and older (Exception: if you have QMB, Medicaid may pay your deductible and coinsurance)
- home births or delivery of a baby outside a hospital, unless it's an emergency
- drugs that have not been proven effective or are experimental
- home remodeling *
- home telephone service
- homemaker services *
- infertility treatment - treatment to help you get pregnant
- massage
- naturopathic services
- plumbing service
- cosmetic surgery
- exercise programs and exercise equipment
- health club memberships
- swim programs
- travel to pharmacy
- ambulance services when some other means of transportation can be used without endangering the health of the patient
- non-emergency transportation (in state or out of state) not authorized prior to transport (See **Transportation**, page 52-53)

* These services might be paid for by Medicaid if you qualify for the Home and Community Based Service program. (See page 58 “Programs That Change How You Get Medicaid”)

If you have questions about Medicaid:
Call the toll-free Medicaid Help Line
1-800-362-8312.

SECTION 3
Other Programs

Programs that change how you get Medicaid

PASSPORT To Health Managed Care Program

Most Medicaid clients must enroll in PASSPORT To Health. The only Medicaid clients who are not enrolled in PASSPORT To Health are those:

- in a nursing home or other institution
- with both Medicare and Medicaid coverage
- classified as medically needy and have an incurment
- receiving Medicaid for less than three months
- living in non-PASSPORT counties
- in subsidized adoption
- whose eligibility is only retroactive
- receiving Home and Community Based Waiver Program Services

If you are enrolled in PASSPORT To Health, you must choose a primary care provider (called a "PASSPORT provider") for your health care needs. If you do not choose a provider, Medicaid will choose a provider for you. A PASSPORT provider can be a doctor, nurse practitioner, physician assistant, or clinic that is practicing primary healthcare and is participating in the PASSPORT program.

You must see your PASSPORT provider for most services or get their authorization before going to another provider or to the hospital for a non-emergency. The okay or authorization should be in writing. If you do not get an okay from your PASSPORT provider for most services, *Medicaid will not pay for the service, and you may have to pay the bill.*

You will receive a letter with your PASSPORT provider's name and 24-hour phone number. If you feel you need to get medical care and your provider's office is closed, call the number to find out where you need to go or what you should do.

If you are required to enroll in the PASSPORT program, you will receive more information on the program. If you have not chosen a PASSPORT provider yet, call the Montana Medicaid Help Line at 1-800-362-8312 to choose a provider.

Team Care program

Millions of dollars are lost annually due to Medicaid fraud or abuse or people over-using Medicaid services. This wastes the State's limited health care resources, often hurting fellow Montanans who are in need. The Team Care program monitors this misuse and ensures members use Medicaid services correctly.

Team Care uses a team of providers and the Nurse First Advice Line to teach Team Care members how to use the health care system properly. If you are identified as a person not using services correctly, you will be automatically enrolled in the program. You will be required to seek services through a primary care provider, select a single pharmacy for your prescriptions, and call the Nurse First Advice Line prior to seeking care. For more information, call your local Office of Public Assistance or the Medicaid Help Line at 1-800-362-8312.

Presumptive eligibility—for pregnant women applying for Medicaid

A pregnant woman can apply for presumptive eligibility for Medicaid from a "Qualified Presumptive Eligibility Provider" (QPEP) such as a City/County Health Department, Family Planning Clinic, or Indian Health Service. Her Medicaid application will be sent on to the local County Office of Public Assistance to be processed. During the application process, if she is determined to be "presumptively eligible" by the QPEP, prenatal care will be guaranteed for up to 45 days, or until her Medicaid eligibility is determined, whichever is less. The provider needs to verify eligibility before providing any service during the presumptive eligibility period. There is no cost share for this service.

Do I lose Medicaid benefits if my financial assistance ends?

You may not lose Medicaid benefits if your financial assistance ends. Your local Office of Public Assistance can give you information about Transitional Medicaid benefits that may provide medical coverage for your family. There are a variety of Medicaid programs available for you and your children, so it is very important to ask your local Office of Public Assistance about coverage options.

Home and community-based services (HCBS)

This Medicaid program provides in-home care and care in an assisted-living facility or adult foster home for those who are physically disabled and elderly.

There are twenty HCBS case management teams in Montana. The teams are made up of one nurse and one social worker for every 60 clients. Case management teams can only have a certain number of clients on the program in a year, so you may have to be put on a waiting list. Ask your eligibility case manager if you want more information.

HCBS serves those 65 or older and those declared disabled by the Social Security Administration. You must be eligible for Medicaid and need the level of services provided in a nursing facility or hospital.

The case management team will meet with you to decide what services you need and how best to meet those needs. Once you agree to a plan, it will be signed by you, the case management team, and your health care provider.

Here is a partial list of HCBS services:

- case management
- personal assistance for supervision and socialization
- modifications to home or vehicle
- supported living or assisted living
- homemaking
- private duty nursing
- special services for people with brain injury
- service dogs
- Meals on Wheels
- respite
- habilitation

Medicaid waiver services for Montanans with a developmental disability (DD waiver services)

The State of Montana provides services to those with developmental disabilities (DD), and their families, with two home and community based waivers. Waiver participation is based on meeting eligibility criteria.

Level-of-care determinations are required annually for all persons in waiver services. Those served under either of the two waivers must remain eligible for Medicaid.

Those in DD waiver services are generally entitled to State Plan Medicaid services based on the eligibility criteria for each of these programs. Waiver services are not entitled. There is a waiting list for service in both of Montana's DD waiver programs.

Services and supports available for those 18 and older in *Community Supports "0371 waiver"* (maximum annual cost not to exceed $7,800) include:

- homemaker, personal care, respite, residential, and work services
- environmental modifications and transportation
- specialized medical equipment and adaptive equipment
- adult companion services and private duty nursing
- social/leisure/recreation services
- health/health safety related services and supports
- education services
- transportation
- residential and work services
- family supports coordination
- supported employment
- personal care, homemaker, respite
- physical therapy, occupational therapy, speech therapy
- environmental modifications
- nutritional and nursing services
- meals (but not a full nutritional regimen)
- respiratory therapy services

For more information about waiver services and program eligibility, contact:

Developmental Disabilities Program - DPHHS
111 Sanders Street
Helena, MT 59604

Phone: (406) 444-2995
Fax: (406) 444-0230

Nurse First programs

Nurse First Advice Line

Any time you are sick, hurt, or have a health care question, you can call the Nurse First Advice Line for friendly, professional advice. The nurses ask simple questions about your health, then help you decide if you need to go to the emergency room, your provider's office, or if you can take care of the problem at home. The service:

- is *free* and *confidential*
- is available 24-hours-a-day, 7-days-a-week
- does not affect your benefits and is available to most Medicaid members.

You are asked to call Nurse First before seeking medical services at your provider's office, health clinic, or emergency department. Nurse First ensures you get the care you need at the right time and place, saves you time and money, and helps fellow Montanans, since Medicaid resources are used more wisely.

All Medicaid members eligible for Nurse First receive program materials in the mail. If you haven't received these materials, contact your local OPA or the Medicaid Help Line at 1-800-362-8312.

Nurse First Disease Management Programs

Nurse First disease management programs are helping Medicaid members with certain types of asthma, diabetes, heart failure, chronic pain, and cancer. The programs are designed to improve their health and quality of life, and help them feel better. Those enrolled learn more about their disease, its effects, and how to help better care for themselves. Members receive:

- One-on-one counseling and education from specially trained, registered nurses
- Program materials such as pamphlets and brochures
- Extensive case management assistance
- Friendly phone calls to see how you're feeling
- In some cases, visits from community-based nurses

Members are automatically enrolled in the programs based on past medical history, or referred to the programs by medical providers, or have self-enrolled. The programs are voluntary and members may withdraw at any time. Contact your local Office of Public Assistance or the Medicaid Help Line at 1-800-362-8312 for details.

Medicare Related Coverage

Qualified Medicare Beneficiary (QMB)

Sometimes Medicaid pays Medicare Part A and Part B premiums. When that happens, the person who gets Medicaid may be on the QMB program. You can be a QMB client if you qualify for Medicare and your income and assets are low and within QMB limits. If you are a QMB client:

- the Medicaid program will pay your Medicare premiums, coinsurance, and deductibles up to the qualified amount;
- only Medicare coinsurance and deductibles will be covered; and
- you are still required to make Medicaid cost shares.

Specified Low-Income Medicare Beneficiary (SLMB)

If you qualify for Medicare, but have too much income to be a Qualified Medicare Beneficiary (see above), Medicaid may pay the Medicare Part B premium. You are only eligible for services *Medicare* covers, not Medicaid services. You will not get a Medicaid card. Medicaid will not pay your Medicare co-insurance or deductibles.

* If you have questions about Medicare-related coverage, call the County Office of Public Assistance in your county. A list of phone numbers for the county offices is in the back of this booklet.

Other Programs For Children

Children's Health Insurance Plan (CHIP)

The Children's Health Insurance Plan (CHIP) offers low-cost or free health insurance for children younger than 19. Children qualify for CHIP if their parents meet income guidelines based on family size, and if:

- the children are residents of Montana and US citizens or qualified aliens,
- the children are not eligible for Medicaid,
- the children do not have health insurance now, and have not had it for the past three months (there are some exceptions),
- the children have parents who do not work for the State of Montana.
- Families who go to the Indian Health Service (HIS) can apply, too.

Eligible children may be placed on a waiting list when application is made.

What's the cost?

- There are small co-payments for some families.
- No family pays more than $215 a year in co-payments.
- There are no co-payments for Well Child checkups, shots, or dental visits!
- There are no premiums for families to pay. The Montana Department of Public Health and Human Services pays the premium each month for each child.

Children can get the following health care services:

- doctor visits and Well Child checkups
- checkups for sports and jobs
- shots
- emergency care
- prenatal care and delivery
- hospital care
- prescription drugs
- clinic visits
- lab and X-ray services
- mental health services
- substance abuse services
- dentist visits
- vision exams and eyeglasses
- hearing exams

Children can qualify even with a pre-existing condition.

If your child has no health insurance and is not eligible for Medicaid, ask your eligibility case manager about CHIP. If your child's Medicaid coverage ends and he or she is eligible for CHIP, coverage can begin when Medicaid ends. Ask your eligibility case manager to tell CHIP that Medicaid ended for your child.

For more information about CHIP, call 1-877-KidsNow (1-877-543-7669), or visit www.chip.state.mt.us.

Children's Special Health Services

Children's Special Health Services assists families of children with special health care needs in locating resources, providing access to specialty services, and financial assistance to families.

Any family can contact Children's Special Health Services (CSHS) for assistance. This can include finding specialists, locating low-cost services, and advocacy training.

CSHS supports and conducts specialty clinical services throughout Montana. Many of the pediatric specialists are brought in from University Medical Centers to eliminate the need for families to travel for such services. Clinics are open to any child who needs assistance. Some of the clinics available in Montana include:

- diabetes
- cystic fibrosis
- pulmonary
- metabolic
- craniofacial
- gastrointestinal
- juvenile arthritis

Children with a special health care need who are living in families under 200% of the federal poverty level who are not Medicaid or CHIP eligible may qualify for assistance for the cost of specialty care. CSHS may assist with expenses related to the condition as long as the program has funding.

To receive more information about resources, clinics, or financial assistance, call 1-800-792-9891 or 444-3622 in Helena. Additional information is available at www.cshs.state.mt.us.

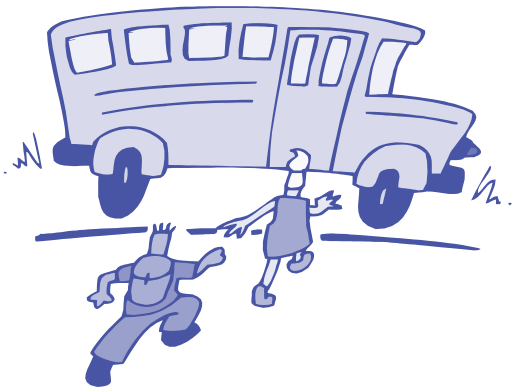
Head Start

Head Start is an early care and education program for low-income children. Head Start serves 3-5 year old children in part-day preschool programs as well as disabled children with special needs.

Head Start services include:

- health and social services
- parent education and support

For more information, call the Head Start program in your community.



County Public Health Departments

These services may be available at your local County Public Health Department:

- immunizations (shots)
- home visits to pregnant women, newborn infants, children
- Well Child check-ups
- communicable disease follow up
- birth control and family planning services
- blood pressure checks
- health fairs
- public health education
- prevention activities

Call to find out what is available. (Phone numbers are on the following pages).

WIC program (special supplement nutrition program for women, infants, and children)

WIC helps low-income women who are pregnant, breastfeeding, or who recently had a baby, and infants and children up to age 5, who are at risk for health problems.

WIC benefits include:

- nutrition evaluation, learning, and guidance to improve eating habits
- referrals to other healthcare and social services
- referrals to private and public health providers
- provide community resource information
- supplemental, high nutrition foods, such as cereal with iron, milk, eggs, peanut butter, beans, juice; and
- iron-fortified milk for mothers who choose not to breast feed.

A person must be:

- pregnant, or
- a breastfeeding woman, or
- a woman who recently had a baby, or
- an infant, birth to 12 months, or
- a child, 1-5 years of age, and
- determined by a health provider to be at medical or nutritional risk and
- meet income guidelines.

WIC has shown positive results in the following ways:

- pregnancy results are improved
- fewer low birth weight babies are born
- diets are improved
- late fetal deaths are reduced
- children are better immunized.
- children do better on vocabulary scores
- anemia rates have gone down

Other Resources

Community Health Centers	Address and Phone Number
Ashland	Ashland Community Health Center, 501 Main 784-2349
Billings	Deering Community Health Center, 123 South 27th Street 247-3350
Billings	Indian Health Board Clinic 1127 Alderson (Tuesday and Thursday afternoons) 245-7318
Billings	Montana Migrant Council, 3318 3rd Avenue North 248-3149
Bozeman	Gallatin Community Clinic, 214 East Mendenhall 585-1360
Butte	Community Health Center, 445 Centennial Drive 723-4075
Cut Bank	Glacier County Community Health Center, 519 East Main 873-5670
Dillon	Dillon Community Health Center, 1260 Atlantic 683-4440
Great Falls	Indian Family Health Clinic, 1220 Central Avenue 268-1510
Great Falls	Community Health Care Clinic, 115 4th Street South 454-6973
Helena	Cooperative Health Center, 1930 9th Avenue 443-2584
Helena	Leo Pocha Clinic, 435 North Jackson 449-5796
Lincoln	Parker Medical Center, Highway 200 West 362-4603
Libby	Lincoln County Community Health Center, 711 California Avenue 293-3755
Livingston	Community Health Partners, 126 South Main Street 222-1111
Miles City	Custer County Community Health Center 210 South Windchester #136 234-8793
Missoula	Partnership Health Center, Inc., 323 West Alder 523-4789
Twin Bridges	Community Health Center Outreach Clinic 104 South Madison (open Wednesday, 2-5 pm) 683-4440

These clinics offer discounted medical and other health services to all members of your family. Fees are on a sliding scale based on income.

List of Resource Agencies

Aging Services Network (Montana)	1-800-551-3191
AIDS Hotline (Montana)…….	1-800-233-6668
(Out of State)…….	1-800-342-2437
Baby Your Baby……..	1-800-421-MOMS (421-6667)
Child Abuse and Neglect	1-866-820-5437
Childhood Lead Poison Prevention Information	1-406-444-5303
Child Support Customer Service	1-800-346-KIDS (346-5437)
Children's Health Insurance Plan (CHIP)	1-877-KIDSNOW (543-7669)
Children's Special Health Services	1-800-762-9891
Children with Disabilities (Parents Let's Unite for Kids)	1-800-222-7585
Citizen's Advocate (problems, questions, complaints about State government)	1-800-332-2272
Eating Disorders……..	1-800-222-2832
Elder Abuse Hotline (Montana)	1-800-551-3191
Food Stamp Hotline (food, clothing, shelter)	1-800-332-2272
Home Health Hotline (complaints)	1-800-762-4618
Legal Services Association	1-800-666-6124
Legislative Auditor Hotline	1-800-222-4446
Medicare……..	1-800-332-6146
Mental Health Services Plan (MHSP)	1-888-866-0328
Mental Health Ombudsman	1-800-444-9669
Nursing Home Problems (Ombudsman)	1-800-332-2272
Poison Control …….	1-800-525-5042
Pregnancy Risk Line…….	1-800-822-2229
Social Security Card …….	1-800-772-1213
Sexually Transmitted Diseases	1-800-233-6668
Special Health Services	1-800-762-9891
WIC-Women, Infants and Children	1-800-443-4298

Montana Directory of County Offices of Public Assistance*

County	Address	Phone
Beaverhead	2 South Pacific #9, Dillon, MT 59725	683-3773
Big Horn	23 West 8th, PO Box 426, Hardin, MT 59034	665-8700
Blaine	100 Chippewa Street West, Harlem, MT 59526	353-4269
Broadwater	124 North Cedar, Townsend, MT 59644	266-3157
Carbon	206 North Broadway, PO Box 670, Red Lodge, MT 59068	446-1302
Carter	10 West Fallon Avenue, PO Box 759, Baker, MT 59313	775-8751
Cascade	201 1st Street So, Ste 1, PO Box 1546, Great Falls, MT 59401	454-5640
Chouteau	1020 13th Street, PO Box 459, Fort Benton, MT 59442	622-5432
Custer	1010 Main Street, Courthouse Basement, Miles City, MT 59301	874-3334
Daniels	100 West Laurel Avenue, Plentywood, MT 59254	765-1370
Dawson	121 South Douglas, Glendive, MT 59330	377-4314
Deer Lodge	307 East Park, Room 305, Anaconda, MT 59711	563-3448
Fallon	10 West Fallon Avenue, PO Box 759, Baker, MT 59313	778-7120
Fergus	312 Birch Street, Suite 1, Lewistown, MT 59457	538-7468
Flathead	2282 Highway 93 South, PO Box 1096, Kalispell, MT 59903	751-5900
Gallatin	237 West Main, Bozeman, MT 59715	582-3010
Garfield	1010 Main Street, Courthouse Basement, Miles City, MT 59301	635-2133
Glacier	101 East Main, PO Box 3025, Browning, MT 59417 505 East Main, Cut Bank, MT 59427	338-5131 873-4113
Golden Valley	201 Kemp Street, Ryegate, MT 59074	568-2231
Granite	220 North Sansomme, PO Box 370, Philipsburg, MT 59858	859-0009
Hill	Courthouse Annex, 302 4th Avenue, Havre, MT 59501	265-4348
Jefferson	North end: 3075 N. Montana Ave., Helena MT 59620 South end: 700 Casey Street, Butte, MT 59701	444-1700 287-9206
Judith Basin	PO Box 427, Stanford, MT 59479	566-2499 Ext.108
Lake	826 Shoreline Drive, Polson, MT 59860	883-7820
Lewis & Clark	3075 North Montana Ave., PO Box 202959, Helena, MT 59620	444-1700
Liberty	Courthouse Annex, 302 4th Avenue, Havre, MT 59501	265-4348
Lincoln	117 Commerce Way, Libby, MT 59923	293-3791

* If the information listed is incorrect, please call the Montana Medicaid Help Line at **1-800-362-8312**.

Montana Directory of County Offices of Public Assistance*

County	Address	Phone
Madison	313 East Idaho, PO Box 75, Virginia City, MT 59755	843-5324
McCone	PO Box 531, Terry, MT 59349	635-2133
Meagher	15 West Main, PO Box 514, White Sulphur Springs, MT 59645	547-3752
Mineral	305 West Main, PO Box 626, Superior, MT 59872	822-4551
Missoula	2677 Palmer, Suite 100, Missoula, MT 59808	329-1200
Musselshell	26 Main Street, Roundup, MT 59072	323-2101
Park	220 East Park, Livingston, MT 59047	222-8000
Petroleum	312 Birch Street Suite 1, Lewistown, MT 59457	538-7468
Phillips	PO Box 1339, Malta, MT 59538	654-2252
Pondera	20 4th Avenue SW, Courthouse, Conrad, MT 59425	271-4020
Powder River	1010 Main Street, Courthouse Basement, Miles City, MT 59301	635-2133
Powell	409 Missouri, Deer Lodge, MT 59722	846-3680
Prairie	PO Box 531, Terry, MT 59349	635-2133
Ravalli	310 North 3rd Street, Hamilton, MT 59840	363-1944
Richland	221 5th Street SW, Sidney, MT 59270	433-2282
Roosevelt	Courthouse Building, Wolf Point, MT 59201	635-1210
Rosebud	121 North 11th Avenue, PO Box 5016, Forsyth, MT 59327 PO Box 276, Lame Deer, MT 59043	356-2563 477-6251
Sanders	2 Tradewinds Way, Thompson Falls, MT 59873	827-4395
Sheridan	100 West Laurel Avenue, Plentywood, MT 59254	765-1370
Silver Bow	700 Casey Street, Butte, MT 59701	496-4900
Stillwater	43 North 4th Street, PO Box 928, Columbus, MT 59019	322-5331
Sweet Grass	115 West 5th Avenue, PO Box 489, Big Timber, MT 59011	932-5266
Teton	20 1st Street NW, PO Box 803, Choteau, MT 59422	466-5721
Toole	226 1st Street South, Shelby, MT 59474	424-8380
Treasure	121 North 11th Avenue, PO Box 5016, Forsyth, MT 59327	356-2563
Valley	501 Court Square, PO Box 9, Glasgow, MT 59230	228-4022
Wheatland	PO Box 4920, Harlowtown, MT 59036	632-4895
Wibaux	1215 Douglas, Glendive, MT 59330	377-4314

* If the information listed is incorrect, please call the Montana Medicaid Help Line at **1-800-362-8312**.

State of Montana Department of Public Health and Human Services

NOTICE OF USE OF PROTECTED HEALTH INFORMATION

Effective Date April 14, 2003

For your protection

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMTION. PLEASE READ IT CAREFULLY.

Private application information

You are applying for government programs that provide money or services. Before we can review your application, we ask that you provide some personal information.

The laws say that:

1. we must keep your Protected Health Information ("PHI") from others who do not need to know it; and
2. you can tell us if there is some PHI you do not wish to be shared. However, in some cases, we may not be able to agree to your request.

Who sees and shares my application and medical information?

Unless you tell us differently on your application, we may share your application information with other programs that may be able to help you. Some are programs for children, people with disabilities, and people who need financial help. If one of these programs can help you, they will contact you.

Healthcare providers who treat you may use your PHI. This may cover healthcare you have had in the past or may have in the future. We may also use your PHI to contact you about appointment reminders or to tell you about treatment alternatives.

We only share the minimum necessary PHI that is needed at the time by that provider or agency.

How is payment made?

Your healthcare provider sends a claim to an insurance company or to a government program for payment. That claim contains all the information about the services you were provided.

Claims that are sent to us are reviewed to assure that you receive the quality health care every client deserves, and that all laws governing medical care are being followed.

May I see my medical information?

You are allowed to see your PHI unless it is the private notes taken by a mental health provider, it is part of a legal case, or if your healthcare provider decides it would be harmful for you to see the information. Most of the time you can receive a copy if requested. You may be charged a small amount for the copying costs.

If you think some of the information is wrong, you may request, in writing, that it be changed or new information be added. You may ask that the changes be sent to others who have received your PHI. You can request and receive a list showing where your medical information has been sent, unless it was sent as part of your provider's care, to assure that you received quality care or to make sure the laws are being followed.

What if my medical information needs to go to another location?

You will be asked to sign a separate form, the Authorization for the Use and Disclosure of Health Information, allowing your PHI to be sent to another location. This would be used if your healthcare provider provides it to another location, or if you request that we send it to another individual or healthcare provider for you.

The form gives the name and address where we are to send your PHI and the information you wish to be provided.

Your authorization is good for six months or until the date you put on the form (not more than 30 months). You can cancel or limit the amount of PHI sent at any time by written notification.

Note: If you are under the age of 18, your parents or guardians will receive your PHI, **unless, by law, you are able to consent for your own healthcare**. If you are, then it will not be shared with them unless you sign an authorization form**.**

Could my information be released without my authorization?

We adhere to laws that provide specific instances when medical information must be shared, even if you do not sign an authorization form. We always report:

1. contagious diseases;
2. reactions and problems with medicines;
3. to the police when required by law or when the courts so order;
4. to the government for audits and reviews of our programs;
5. to a provider or insurance company to verify your enrollment in one of our programs;
6. to Workers' Compensation for work related injuries;
7. birth, death and immunization information; and
8. to the federal government if required to investigate any matter pertaining to the protection our country, the President, or other government workers.

May I have a copy of this notice?

This notice is yours. If the information changes, you will be provided a copy of the updated notice. If you have questions concerning this notice, please ask the individual providing it. If that individual cannot answer your questions, call the Department of Public Health and Human Services (DPHHS) Privacy Officer at (800) 645-8408.

You can also complain to the federal government's Secretary of Health and Human Services by writing to: 200 Independence Ave. SW, Washington, DC 20201. This must be done within 180 days from the date you believe your privacy was violated. You can also complain to the Office for Civil Rights by calling (866) 627-7748.

Your Medicaid benefits will not be affected by a complaint made to the DPHHS Privacy Officer or to the Secretary of Health and Human Services.

I have been given a copy of this notice and have been given the opportunity to ask questions concerning how my Protected Health Information will be used. I know that I can contact the DPHHS Privacy Officer at (800) 645-8408 if I have further concerns.

_____ _____

Signature **Date**

Notes:

Notes:

Notes:

Notes:

My Office of Public Assistance case manager is: _____

_____

_____

Phone Number: _____

_____

My local Health Department: _____

_____

Phone Number: _____

_____

Low Income Energy Assistance (LIEAP): _____

_____

Job Service: _____

_____

Community Health Center: _____

_____

Medicaid Help Line: 1-800-362-8312

Other numbers: _____

_____

_____

Montana Medicaid Website: www.mtmedicaid.org

MONTANA
Department of Public Health & Human Services

Cogswell Building
1400 Broadway
PO Box 202951
Helena, MT 59620-2951

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